UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:

City of Detroit, Michigan,

Debtor.

_____/

Bankruptcy Case No. 13-53846
Honorable Thomas J. Tucker
Chapter 9

EXHIBIT D (BLUE CROSS PLAN) IN SUPPORT OF DPLSA'S RESPONSE IN OPPOSITION TO CITY OF DETROIT'S MOTION FOR (I) DETERMINATION THAT THE DETROIT POLICE LIEUTENANTS AND SERGEANTS ASSOCIATION HAS VIOLATED THE TERMS OF THE CITY OF DETROIT'S CONFIRMED PLAN OF ADJUSTMENT AND THE ORDER CONFIRMING IT; AND (II) ORDER (A) ENJOINING FURTHER VIOLATIONS AND (B) REQUIRING DISMISSAL OF STATE ACTIONS [DOCKET NO. 9656]

PART 14 OF 14

Section 8: Other Information You Should Know About Your Coverage

Blue Cross Blue Shield of Michigan wants you to be satisfied with the services you receive as a member. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact Customer Service. The telephone number can be found on the back of your Blues ID and the top right hand corner of your Explanation of Benefit Payments statements.

Grievance Process

We have a formal grievance and appeals process if you are unable to resolve your concerns through Customer Service, or wish to contest an adverse benefit decision.

An adverse benefit determination is a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

If you choose to file a grievance or appeal:

- You will not incur additional charges for filing a grievance or appeal, and you may submit written materials or testimony to help us in our review at any step of the grievance or appeals process.
- You may authorize another person, including your physician, to act on your behalf at any stage in the standard internal grievance procedure. Your authorization needs to be in writing. Please call the customer service number on the back of your Blues ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.
- Although we have 35 days to give you our final determination, you have the right to allow us additional time if you wish.
- You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service free of charge.

The grievance and appeals process begins with an internal review by BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

Standard Internal Grievance Process

You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment.

Grievance Process (continued)

Standard Internal Grievance Process (continued)

Mail your written grievance to:
Appeals Unit
Blue Cross Blue Shield of Michigan
P.O. Box 2459
Detroit, MI 48231-2459

Once we receive your grievance, we will contact you to conduct or schedule a conference. That will be your opportunity to provide us with any additional information or testimony you want us to consider in reviewing your claim. You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit, during regular business hours. Our written resolution will be our final determination regarding your grievance.

If you disagree with our final determination, or if we fail to provide it to you within 35 days of the date we received your original written grievance, you may request an external review from the Michigan Department of Insurance and Financial Services.

Standard External Review Process
Once you have exhausted our standard internal grievance process, you or your authorized representative may request an external review from the Director of Financial and Insurance Services.

The standard external review process is as follows:

1. Within 60 days of the date you received our final determination, or should have received it, send a written request for an external review to the Director. Mail your request, including the required forms that we will supply to you, to:

   Department of Insurance and Financial Services
   Office of General Counsel
   Health Care Appeals Section
   P.O. Box 30220
   Lansing, MI 48909-7720

2. If your request for external review concerns a medical issue and is otherwise found to be appropriate for external review, the Director will assign an independent review organization, consisting of independent clinical peer reviewers, to conduct the external review.

   - You will have an opportunity to provide additional information to the Director within seven days of submitting your request for an external review. We must provide documents and information considered in making our final determination to the independent review organization within seven business days after we receive notice of your request from the Director.

   - The assigned independent review organization will recommend within 14 days whether the Director should uphold or reverse our determination. The Director must decide within seven business days whether or not to accept the recommendation and will notify you. The Director's decision is the final administrative remedy under the Patient's Right to

Independent Review Act of 2000.

Grievance Process (continued)

Standard External Grievance Process (continued)

If your request for external review is related to nonmedical issues and is otherwise found to be appropriate for external review, the Director's staff will conduct the external review.

The Director's staff will recommend whether the Director should uphold or reverse our determination. The Director will notify you of the decision, and the Director's decision is your final administrative remedy.

Expedited Internal Grievance
If a physician substantiates (either orally or in writing) that adhering to the timeframe for the standard internal grievance process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance.

You may file a request for an expedited internal grievance only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service, or if you believe we have failed to respond in a timely manner to a request for benefits or payment.

The procedure is as follows:

- You may submit your expedited internal grievance request by telephone to 313-225-6800. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.

- We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Director of the Department of Insurance and Financial Services.

Expedited External Grievance
If you have filed a request for an expedited internal grievance, you may request an expedited external review from the Director of Insurance and Financial Services.

You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service.

The expedited external review process is as follows:

- Within 10 days of your receipt of our denial, termination or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Director by calling 1-877-999-6442 to request the forms required.

Grievance Process (continued)

Expedited External Grievance (continued)

- Mail your request, including the required forms that we will give you, to:

  Department of Insurance and Financial Services
  Office of General Counsel
  Health Care Appeals Section
  P.O. Box 30220
  Lansing, MI 48909-7720

Immediately after receiving your request, the Director will decide if it is appropriate for external review and assign an independent review organization to conduct the expedited external review. If the independent review organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Director should uphold or reverse our determination.

The Director must decide within 24 hours whether or not to accept the recommendation and will notify you. The Director's decision is the final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Pre-Service Appeals

For members who must get approval before obtaining certain health services.

If your health plan requires you to get approval before obtaining certain health services, and you disagree with our decision not to approve a service, you have the right to appeal it.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the customer service number on the back of your Blues ID card.

All appeals must be requested in writing. We must receive your written request within 180 days of the date you received notice that the service was not approved.

Requesting a Standard Review

You may make the request yourself, or your doctor or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the customer service number on the back of your Blues ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.

Your letter requesting a review must include the following information:

- Your contract and group numbers, found on your Blues ID card
- A daytime phone number for both you and your representative
- The patient's name if different from the member
- A statement explaining why you disagree with our decision and any additional supporting information

Pre-service Appeals (continued)

Requesting a Standard Review (continued)

Once we receive your appeal, we will provide you with our final decision within 30 days.

Requesting an Urgent Review
If your situation meets the definition of urgent under the law, your review will be conducted as soon as possible; generally within 72 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent review. You may also request a simultaneous external review.

For more information on how to request an urgent review or simultaneous external review, call the customer service number listed on the back of your Blues ID card.

For more information
At your request and without charge, we will send you details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the customer service number on the back of your Blues ID card.

Other resources to help you
For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You can also contact the Department of Insurance and Financial Services for assistance.

Other Provisions of your Coverage

Genetic Testing

We will not:

- Adjust premiums for this coverage on genetic information related to you, your spouse or your dependents
- Request or require genetic testing of anyone covered under this certificate
- Collect genetic information from anyone covered under this certificate at any time for underwriting purposes

Section 9: How to Reach Us

This section lists phone numbers and addresses to help you get information quickly. You may call or visit our BCBSM Customer Service center.

To Call

Most of our BCBSM Customer Service lines are open for calls from 8:30 a.m. to noon and from 1 to 5 p.m., Monday through Friday. Please have your ID card with your group and contract numbers ready when you call.

Area code 248, 313, 586, 734, 810 or 947
Southeast Michigan toll-free 1-877-790-2583

Area code 231, 269 or 616
West Michigan toll-free..... 1-800-972-9797

Area code 517 or 989
Central Michigan toll-free 1-800-258-8000

Area code 906
Upper Peninsula toll-free..... 1-800-562-7884

For when you are out-of-state, call BlueCard..... 800-810-2583

For when you are out of the country, call BlueCard Worldwide ..... 804-763-1177 (call collect)

To Visit

BCBSM Customer Service centers are located throughout Michigan. Check the following list or visit our website at bcbsm.com to find the center nearest you. The centers are open Monday through Friday, 9 a.m. to 5 p.m.

Detroit
600 E. Lafayette Blvd., Detroit 48226
Downtown, three blocks north of Jefferson at St. Antoine

Flint
4520 Linden Creek Parkway, Suite A, Flint 48507

Grand Rapids
86 Monroe Center N.W., Grand Rapids 49503

Holland
151 Central Ave., Holland, 49423

To Visit (continued)

Lansing
232 S. Capitol Ave., Lansing 48933

Marquette
415 S. McClellan Ave., Marquette 49855
Up on the hill

Portage
8175 Creekside Dr., Suite 100, Portage 49024

Traverse City
City Centre Plaza
202 State St., Traverse City 49686

Utica
6100 Auburn Road, Utica 48317
Diagonally across from the AAA building

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